LIBERTY MUTUAL
Liberty Life Assurance Company of Boston

APPLICATION FOR

LONG TERM DISABILITY

EMPLOYEE'S DISABILITY BENEFITS APPLICATION

RETURN TO:
Liberty Life Assurance Co.
P. O. BOX 1525
DOVER, NH 03820-1525
ATTN: DISABILITY PRODUCTS
1-800-451-7065-Ext. 31543

TO BE COMPLETED BY EMPLOYEE

CLAIMANT

1. Full Name (Last, First, Middle Init.): SCAPICCHIO, ANTHONY P.
2. Social Security Number: 024-28-8555
3. Phone Number: area code (617) 581-1310
4. Address: 240 NAHANT RD City: NAHANT State: MASS. Zip Code: 01908
5. Date of Birth: Mo. Day Year 12 18 37
6. Height: 5'10"
7. Weight: 220#
8. Sex: ☒ M ☐ F
9. Marital status: ☐ Single ☒ Married ☐ Widowed ☐ Divorced
10. Spouse's date of birth: 7 8 42 (Mo. Day Year) First Name: DIANA
11. Is spouse employed? ☐ Yes ☒ No
12. Number of children (Under age 19): 1
13. List names and dates of birth of unmarried children who have not finished high school.

EMPLOYMENT

14. Employer's Name: MT. AUBURN Hospital 330 MT. AUBURN ST. CAMB. MA 02238
15. Group Policy No.
16. Occupation (List the duties of your occupation at the time of disability): Staff attending PHYSICIAN - Emergency Dept.
17. Date of accident or date first noticed symptoms of illness: 1 95 (Mo. Day Year)
18. I have been unable to work because of the disability since: 2 1 95 (Mo. Day Year)
19. I returned to work on a part-time basis on: N/A Mo. Day Year
20. I returned to work on a full-time basis on: N/A Mo. Day Year
21. Is your accident or illness related to your occupation? ☐ Yes ☒ No
22. If "yes" explain

Have you or do you intend to file a Workers' Comp. Claim? ☐ Yes ☒ No

CLAIM HISTORY

23. Describe how and where accident occurred or describe the onset and nature of your illness.
Progressive Depression

24. Date you were first treated for your illness or injury: 1 13 95 (Mo. Day Year)

25. Treated by:
Hospital:
Doctor: Bernard Levy MD 17 Berwick RD Newton MA 02159 (Name, Street Address, City, State, Zip Code)

26. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No
3 92 (Mo. Day Year)
If "yes" complete No. 27

27. Treated by:
Hospital:
Doctor: Bernard Levy MD 17 Berwick RD Newton MA 02159 (Name, Street Address, City, State, Zip Code)

INCOME

28. Describe other income you are receiving:

Yes	No	Type	Amount	Date Began	Date Term.
☐	☐	Social Security (disability or retirement)	$		
☐	☐	State disability	$		
☐	☐	Retirement (normal, early or disability)	$		
☐	☐	Workers' Compensation	$		
☐	☐	Group disability benefits	$		
☒	☐	Other (describe) V.A. for Ulcer Disease	$ 666/mo	1969	→

BENEFIT

29. Have you, or do you plan to, apply for any of the other income benefits listed in question 28? Have not.
Type ______ Date application filed ______
Type ______ Date application filed ______

30. If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purposes?
☒ Yes ☐ No If "yes" Amount $ to be determined
Indicate amount per month-$20.00 min.

Anthony P. Scapicchio
Signature

Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

[signature] Signature of Employee   Ap 20, 1995 Date

Dis-Prod. 200

I AUTHORIZE any licensed physician, medical practitioner, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to the particular Company in the Liberty Mutual group of companies to which I am submitting a claim, or to its legal representative.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance benefits. Any information obtained will not be released by the Company to any person or organization EXCEPT to reinsuring companies or other companies in the Liberty Mutual group of companies to which I submit claim for insurance benefits.

I KNOW that I may request a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall be valid during the pendency of my claim.

If I receive a disability benefit payment greater than that which should have been paid, I understand that the Insurance Company has the right to recover such over payment from me, including the right to reduce future disability benefits, if any.

I certify that the above information is true and correct.

DATE	EMPLOYEE'S SIGNATURE
Apr 20, 1995	▶ Anthony Scapucci Leo

BERTY UTUAL.
rty Life
rance Company of Boston

LONG TERM DISABILITY
ATTENDING PHYSICIAN'S STATEMENT
(To Avoid Delay Please Answer All Questions)
(This form is to be completed without expense to the Company)

RETURN TO:
Liberty Life Assurance Co.
P. O. BOX 1525
DOVER, NH 03820–1525
ATTN: DISABILITY PRODUCTS
1-800-451-7065–Ext. 31543

me of Patient (Print)	Date of Birth	Claim No.
SCAPICCHIO, ANTHONY	12/18/37	

sent No. Street	City	State (or Province)	ZIP Code
dress 240 NAHANT ROAD	NAHANT,	MA	01908

Group Insurance, Give Name of Policyholder
. Employer, Union or Association through whom insured) MT. AUBURN Hospital, Cambridge, MA

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

: patient is responsible for the completion of this form without expense to the Company. Space is available on the reverse side if you wish mplify your answers.

HISTORY

(a) When did symptoms first appear or accident happen? — Mo. January Day ____ 19 95

(b) Date patient ceased work because of disability. — Mo. Feb Day 1 19 95

(c) Has patient ever had same or similar condition? — Yes ☑ No ☐

If "Yes" state when and describe. Previous milder episode March, '92

PRESENT CONDITION

(a) Subjective symptoms — Major Depression

(b) Objective findings

Include results of current X-rays, E.K.G.s, or any other special tests.

(c) Is patient: ..... — Ambulatory? ☑ Bed confined? ☐ House confined? ☐ Hospital confined? ☐

DIAGNOSIS — Major Depression 296.24

TREATMENT

(a) Date of first visit ..... — Mo. 1 Day 13 19 95

(b) Date you verified total disability ..... — Mo. ____ Day ____ 19 ____

(c) Date of last visit ..... — Mo. 4 Day 11 19 95

(d) Frequency of visits ..... — Weekly ☑ Monthly ☐ Other ____

(e) When did you last examine the patient? ..... — Mo. 4 Day 11 19 95

PROGRESS — Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed ☐

EXTENT OF DISABILITY

	FOR ANY OCCUPATION	FOR HIS/HER REGULAR OCCUPATION
(a) Is patient now totally disabled?	Yes ☐ No ☑	Yes ☑ No ☐
(b) If no, when was patient able to go to work?	Mo. ____ Day ____ 19 ____	Mo. ____ Day ____ 19 ____
(c) If yes, when do you think patient will be able to resume any work? — Approximate Date	Mo. ____ Day ____ 19 ____	Mo. ____ Day ____ 19 ____
Indefinite	☐	☑
Never	☐	☐
(d) Is the patient competent to endorse checks and direct use of the proceeds thereof?	Yes ☑ No ☐	

7. REHABILITATION	FOR ANY OCCUPATION	FOR HIS/HER REGULAR OCCUPATION
(a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.)	Yes ☐ No ☐	Yes ☑ No ☐
(b) Can present job be modified to allow for handling with impairment?	Yes ☐ No ☐	
(c) When could trial employment commence?	Mo. ____ Day ____ 19 ____	Mo. ____ Day ____ 19 ____
	Full-time ☐ Part-time ☐	Full-time ☐ Part-time ☐
(d) Would vocational counseling and/or retraining be recommended?	Yes ☐ No ☑	

8. PHYSICAL IMPAIRMENTS (*As defined in Federal Dictionary of Occupational Titles)

- ☐ Class 1—No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%)
- ☐ Class 2—Medium manual activity* (15-30%)
- ☐ Class 3—Slight limitation of functional capacity; capable of light work* (35-55%)
- ☐ Class 4—Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
- ☐ Class 5—Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)

Remarks:

9. MENTAL IMPAIRMENTS (If applicable)

(a) Please define "stress" as it applies to this claimant. Emergency Room medical practice

(b) What stress and problems in interpersonal relations has claimant had on job?

- ☐ Class 1—Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2—Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3—Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☑ Class 4—Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5—Patient has significant loss of psychological, physiological, personal and social adjustment (servere limitations)

Remarks:

Complete appropriate section, if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT.

10. CARDIAC IMPAIRMENT	
(a) Functional capacity (*American Heart Ass'n*)	Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation) ☐
(b) Blood pressure	

11. VISUAL IMPAIRMENT	(*Snellen Notation*)
(a) What was vision at last observation ..... With Glasses	O.D. ____ O.S. ____ Mo. ____ Day ____ 19 ____
Without Glasses	O.D. ____ O.S. ____ Mo. ____ Day ____ 19 ____
(b) Date *corrected* vision was irrecoverably reduced to 20/200 or less in the better eye	Mo. ____ Day ____ 19 ____ O.D. ☐ O.S. ☐
(c) Vision can be restored in whole or in part by	O.D. Lenses ☐ Treatment ☐ Operation ☐ Not restorable ☐
	O.S. Lenses ☐ Treatment ☐ Operation ☐ Not restorable ☐

REMARKS:

Name (Attending Physician) Print	Degree	Telephone (617) 969-1734 Area Code
Bernard Levy, M.D.		
Street Address: 17 Berwick Road	City or Town: Newton. MA 02159-2122	State or Province	ZIP Code
Signature: Bernard Levy MD	Tax ID. No. or S.S. No. 216-34-5481	Date 4/14/95

LIBERTY MUTUAL
Liberty Life Assurance Company of Boston

LONG TERM DISABILITY

Liberty Life Assurance Co.
P. O. BOX 1525
DOVER, NH 03820-1525
ATTN: DISABILITY PRODUCTS
1-800-451-7065-Ext. 31543

EMPLOYER'S REPORT OF CLAIM

TO BE COMPLETED BY EMPLOYER

CLAIMANT

1. Employee's Name: ANTHONY P. SCAPICCHIO
2. Social Security No.: 024-28-8555
3. Date of Birth: 12/18/37
4. Address: 240 NAHANT ROAD, City: NAHANT, State: MA, Zip Code: 01908

EMPLOYMENT

5. Insurance Class: LHIRA/PLAN 2 CLASS 3
6. Employee Date of Hire: 9/1/74
7. Date employee became insured for LTD 7/1/94 - Base Coverage; 10/1/94 - Supplemental
8. Date employee was actually last present at work: 2/1/95
9. Occupation at time last worked (attach job description): STAFF PHYSICIAN
10. Work schedule at time last worked: No. of days per week 5; No. of hours per day 8
11. Reason for stopping: ☒ Sickness ☐ Granted LOA ☐ Laid Off ☐ Retired ☐ Dismissed ☐ Other ☐ Resigned ☐ Vacation
12. Has employee returned to work? ☐ Yes ☐ Part-time ☐ Full-time ☒ No Date _____ Date _____

INCOME

13. How is employee paid? ☒ Straight Salary ☐ Hourly ☐ Salary & Commissions ☐ Commissions Only ☐ Salary & Bonus
14. Employee's Basic Monthly Earnings: $ ~~12,461.~~ 13,435.00 GROSS LTD Benefit 70% (If salary is based on less than 12 months—No. of months _____)
15. Employee's % of LTD premium contribution: Employee pays 100% of SUPPLEMENTAL COVERAGE/0% of BASE COVERAGE; Employer pays 0% of BASE COVERAGE/100% of SUPPLEMENTAL COVERAGE

OTHER BENEFITS

16. Has insured received other disability payments since time last worked?
Salary Continuance: ☒ Yes Wkly. Amt. 3,100.40 GROSS Date benefits cease 6/30 last pay - verbally given to Tiffany ☐ No
Insured Short Term: ☐ Yes Wkly. Amt. _____ Date benefits cease _____ ☒ No
Other Type: ☐ Yes Wkly. Amt. _____ Date benefits cease _____ ☒ No

17. Did claim result from job activity ☐ Yes (Explain) ☒ No
18. Has Workers' compensation claim been filed? N/A ☐ Yes ☐ Pending ☐ Denied (Enc. copy)
19. Workers' compensation Weekly Amount $ _____ N/A (Inc. copy of 1st report of accident)

RETIREMENT

20. Is employee covered by employer sponsored retirement plan? ☒ Yes ☐ No
21. Does retirement plan contain a disability provision? ☐ Yes ☒ No
22. Is employee or will this employee be eligible for a disability or retirement pension? ☒ Yes ☐ No If "Yes" type: defined contribution retirement plan Monthly Amount $ N/A - unable to determine ultimate monthly payments. ☐ Disability ☐ Retirement ☐ Other _____
Percent of employee contributions: _____%
Percent of employer contributions: _____%
Commence Date of Benefits: Not eligible until at least age 59 1/2 (enclose copy of summary plan description)

CERTIFICATION

23. Employer's Name (state association and name of policyholder if other): MOUNT AUBURN HOSPITAL
24. Facsimile No.: (617) 499-5168 Area Code
25. Group Policy No.: 10-244052-0001
26. Address: 330 MOUNT AUBURN STREET CAMBRIDGE, MA 02238
27. Employer (Taxpayer) I.D. Number (EIN): 04-2103606
OR
28. Public Employer Social Security No. 69 _____-_____
29. Name of person completing this form (please type or print): NANCY E STRYKER
30. Signature of person completing this form: Nancy E Stryker
31. Telephone No.: (617) 499-5139 Area Code
Title: BENEFITS SPECIALIST
Date: 5/15/95

DisProd 301